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May 16, 2006

AGENDA ITEM 9

TO: MEMBERS OF THE HEALTH BENEFITS COMMITTEE

I. SUBJECT: First Reading – Blue Shield Proposal: Service Area and Benefit Design Alternatives for Certain Exclusive Provider Organization and Direct Contract Counties

II. PROGRAM: Health Benefits

III. RECOMMENDATION: Information Only

IV. INTRODUCTION:

The outcome of detailed analyses conducted by Blue Shield of California (Blue Shield) indicates that to preserve and promote cost effective health care benefits for as many state and contracting agency enrollees as possible, consideration should be given to modifying the current Blue Shield Health Maintenance Organization (HMO) service area. This modification would include: 1) discontinuing Blue Shield's HMO product in five (5) Exclusive Provider Organization (EPO) counties and limiting the health plans offered in those areas to the CalPERS Self-Funded Preferred Provider Organizations (PPO); and 2) offering a new Blue Shield POS Point of Service (POS) plan in eight (8) Direct Contract (DC) counties (excluding Medicare Supplement) in lieu of an HMO option. This approach will improve pricing for approximately 314,000 members which is 85% of the current Blue Shield membership and impact 5,300 members in the EPO counties and 47,000 members in the DC counties.

V. BACKGROUND:

As a condition of a 3-year exclusive HMO network contract (January 1, 2004 – December 31, 2006), CalPERS required Blue Shield to continue to provide coverage in 40 of the 58 California counties. HMO coverage in these counties had been provided by Blue Shield, PacifiCare, and Health Net prior to the consolidation and 3-year HMO network contract with Blue Shield.

As the exclusive CalPERS HMO network plan, Blue Shield attempted to negotiate contracts (capitation and utilization management requirements) in many counties that had been, and continue to be, resistant to managed care. Most providers would not agree to managed care provisions within their contracts, therefore, to deliver on the CalPERS requirement, it was necessary for Blue Shield to enter into reimbursement agreements on a discounted fee-for-service basis with limited

utilization management rights. As a result, the current Blue Shield HMO network is a three-tier delivery system which includes:

- **6 EPO counties** (Colusa, El Dorado, Lake, Mendocino, Plumas, and Sierra) where health care is delivered much like that of a PPO plan – no primary care provider is selected or coordinates specialty referrals and diagnostics, and utilization management is limited primarily to inpatient hospital admissions. There is often only one hospital provider, which limits Blue Shield's ability to negotiate facility reimbursements. Therefore, these facilities tend to be significantly more expensive than the average. There is a limited physician specialty pool so consequently patients seek health care outside of the Blue Shield HMO network, opting into the Blue Shield PPO network.

- **10 DC counties** (Butte, Glenn, Mariposa, Merced, Napa, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, and Sonoma) where health care is delivered through a primary care provider. However, as with the EPO counties, some physician specialties are limited and hospital options are minimal resulting in reimbursement costs greater than the average.

- **24 managed care counties** (Core HMO) where provider reimbursement agreements are largely based on capitation or per diem methodology, providing the incentive for providers to deliver health care services at the appropriate level and location.

During the past two years, Blue Shield has conducted focused analyses on health care cost drivers. These analyses indicate that 5 of the EPO counties and 8 of the DC counties are having a disproportionate impact on the health care costs for the CalPERS-Blue Shield network model HMO. These counties are as follows:

EPO – Colusa, Lake, Mendocino, Plumas, and Sierra
DC – Butte, portions of El Dorado County, Glenn, Mariposa, Napa, San Luis Obispo, San Mateo, and Sonoma

Blue Shield's data indicates that health care trends in the EPO counties have reached nearly three times the average of the Core HMO counties. Health care trends in DC counties have been nearly double that of Core HMO counties. In addition to the type of reimbursement (discounted fee-for-service) and limited ability to manage utilization, increased costs can also be attributed to minimal membership volume in these counties, limiting CalPERS' purchasing power.

Because continually increasing health care costs in these EPO and DC counties have a substantially negative impact on the HMO network premiums, Blue Shield proposes:

- Discontinuation of its HMO product in 5 of the EPO counties (**Colusa, Lake, Mendocino, Plumas, and Sierra**). This represents 5,300 total covered

lives. Note that an HMO option in some Colusa zip codes is available through Western Health Advantage, and in the remaining four counties and Colusa zip codes where no HMO plan is available, state enrollees are expected to qualify for the Rural Health Care Equity Program (RHCEP) administered by the Department of Personnel Administration (DPA); see Attachment 1.

- Introduction of a new Point of Service (POS) plan in lieu of an HMO plan for 8 DC counties (**Butte, El Dorado, Glenn, Mariposa, Napa, San Luis Obispo, San Mateo, and Sonoma**). This represents approximately 47,000 total covered lives but does not affect MediCare supplement members. Note that a Kaiser HMO option exists in Napa, San Mateo, and Sonoma. The Western Health Advantage HMO is available in some El Dorado county zip codes. In the remaining four counties and El Dorado zip codes where no HMO plan is available, state enrollees are expected to qualify for the RHCEP benefits administered by the DPA; see Attachment 1.

The proposed service area and plan changes will result in lower premium increases for 24 HMO counties covered by Blue Shield in 2007. This includes the 21 Core HMO counties plus Merced, Santa Barbara and Santa Clara. Lower price increases will enable CalPERS to moderate pricing for Core HMO network benefits delivered through Blue Shield, as well as attract and retain public agency participation.

VI. ANALYSIS:

Exclusive Provider Counties (EPO)

The Blue Shield data analysis, verified by staff, indicates that health care costs in EPO counties range from 20% to 100% greater than the average cost of health care in Core HMO counties. In 2005, health care trends were as much as 300% greater than the approximate 8.5% trend experienced in Core HMO counties. Contributing to the high cost of health care are:

- Diagnostics (lab, radiology, etc) -- ordered at rates nearly two times greater than the average per 1,000 members;
- Physician office visits -- more than two times greater than the average per 1,000 members;
- Significantly higher hospital costs per day;
- More frequent out-of-network utilization of Blue Shield PPO providers.

In its analysis of EPO counties, Blue Shield has determined that neither it nor any other health plan is likely to have much success attempting to direct and manage care in EPO counties due to high unit costs primarily for specialists and hospitals, and CalPERS' limited ability to leverage purchasing power (due to a lower volume of enrollment).

Direct Contract Counties (DC)

The Blue Shield data analysis, verified by staff, indicates that health care costs in 8 DC counties range from 10% to 45% higher than the average cost of health care in Core HMO counties. Health care trends in 2005 were nearly 200% greater than the approximate 8.5% trend in Core HMO counties. As in EPO counties, costs for diagnostic tests and physician office visits are nearly double the utilization in Core HMO counties, and specialty and hospital costs are greater due to fewer options being available as well as limited CalPERS' purchasing power.

Rather than eliminate a health plan offering in the DC counties, Blue Shield proposes to moderate future costs in these counties by replacing its HMO plan with a new Point of Service (POS) plan.

Point of Service (POS) Plan

The proposed POS product (Attachment 2) is designed to align member incentives to influence appropriate levels of care in the most cost effective location. The benefit design should shift enrollee utilization to physician office visits as well as free-standing ambulatory surgery centers (when appropriate), rather than hospital based services.

A POS product will provide members with the flexibility to go outside of the Blue Shield POS network, into the Blue Shield PPO network with an increased coinsurance payment; however, it is important to note that all services are available within the Blue Shield POS network. Please note that the Blue Shield PPO is not significantly more robust than the POS in these counties, however, members periodically prefer to access more highly specialized services outside of these counties where the Blue Shield PPO is more robust. In addition, members who select the Blue Shield POS product will retain access to disease management programs, Healthy Lifestyle Rewards, and other benefits available through Blue Shield.

Pricing Impact of DC and EPO County Recommendations

The Blue Shield proposal to discontinue its HMO plan in 5 EPO counties (Colusa, Lake, Mendocino, Plumas, and Sierra) and introduce a new POS plan with separate pricing in 8 counties (Butte, El Dorado, Glenn, Mariposa, Napa, San Luis Obispo, San Mateo, and Sonoma) is projected to reduce the overall basic rate by approximately 3%. Additional illustrative data is being developed for distribution and discussion at the May Constituent and CalPERS Health Benefits Committee meetings.

To ensure future costs of health care are better controlled in the 8 non-Core HMO counties, Blue Shield has committed to:

- Conduct even more detailed medical analytics to improve understanding of health care cost drivers;

- Intensify medical management to gain better control of utilization and channel patients to appropriate providers and levels of care;
- Perform provider efficiency modeling to identify opportunities for education and incentives to change behavior;
- Organize regional council meetings to make health care cost drivers transparent as well as evaluate and implement plans for lowering costs.

Although Blue Shield's recommendation will eliminate an HMO choice for approximately 5,300 total covered lives in 5 EPO counties and introduce a new POS plan in 8 counties affecting approximately 47,000 total covered lives (MediCare Supplement is not affected), it will result in improved pricing for approximately 314,000 members in the other 27 HMO counties.

VII. STAFF RECOMMENDATION:

This in an information item.

VIII. STRATEGIC GOAL:

This item supports Goal X of the strategic plan which states, "Develop and administer quality, sustainable health benefits programs that are responsive to and valued by enrollees and employers."

The Blue Shield analysis and subsequent proposal supports long-term sustainability and viability of health care benefits through benefit design, pricing, and appropriate incentives for behavioral change.

IX. RESULTS/COSTS

This is an information item. Representatives from Blue Shield will make a detailed presentation that will be distributed at the meeting.

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Attachments